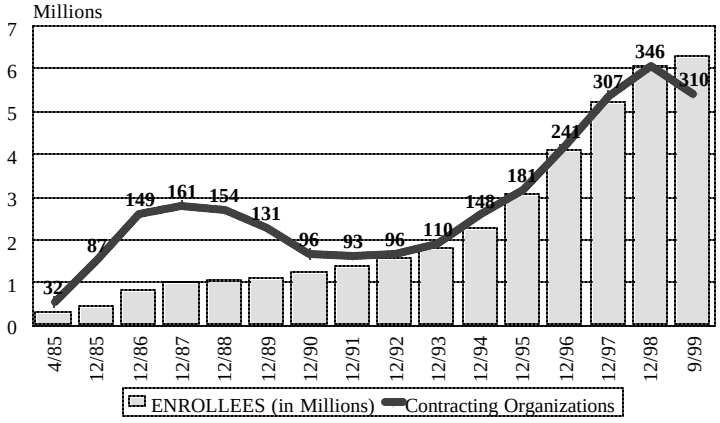
MEDICARE+CHOICE: CHANGES FOR THE YEAR 2000

Since the creation of Medicare+Choice (M+C) in 1997, the Health Care Financing Administration (HCFA) has been working continuously to ensure that there is a wide range of high-quality health care options available to Medicare beneficiaries and to improve the operation of M+C for the private companies that choose to serve them. As part of this effort, HCFA has devoted a significant amount of time and effort to developing a better understanding of the program's successes and shortcomings. This report represents our latest effort to help Congress, the managed care industry, interested parties, and --most importantly-- Medicare beneficiaries and their advocates to understand how M+C is evolving.

Beneficiary Enrollment and Managed Care Organization Participation

Despite recent volatility in the managed care market, an ever-increasing percentage of Medicare beneficiaries choose to enroll in M+C organizations.[1] Total Medicare managed care enrollment has more than doubled in the past four years, from 3.1 million at the end of 1995 to 6.3 million in 1999. About one in every six beneficiaries is now enrolled in an M+C organization, and the enrollment rate among those Medicare

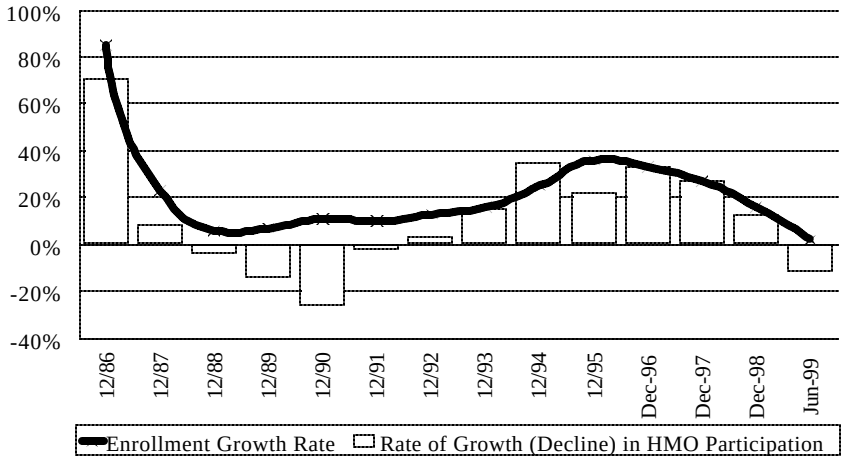
Medicare Risk HMO/M+C Enrollment and HMO Participation, 1985-1999



[1] As a result of provisions of the Balanced Budget Act of 1997 (BBA), the terms *organization* and *plan* have specific meanings in the context of the M+C program. The methodology section of the paper explains the difference in these definitions and the relevance to our analysis. Please see the methodology section for an explanation of several other key issues related to the development of this report.

beneficiaries who live in an area served by one or more M+C organizations is about 23 percent (nearly one in four Medicare beneficiaries chooses an M+C plan where one is available).

Yearly Medicare Risk Enrollment Growth Rates and Rates of Change in HMO Participation Levels, 1986-1999



We anticipate that program growth will continue in the long-term despite decisions by some organizations to discontinue participation in the M+C program for the 2000 contract year. Despite the fact that health maintenance organization (HMO) participation in the program has been volatile—and has even declined during certain periods—beneficiary enrollment has increased consistently. Enrollment losses resulting from reductions in organization participation in the 1999 contract year were recouped within just two months. Enrollment in Medicare risk organizations (today's M+C organizations) has grown every year since the inception of the program in 1985.

Even though the level of access to M+C plans has remained relatively stable in the last few years, the absolute number of beneficiaries enrolling in M+C each month has dropped. During 1997, the size of the M+C program increased by 91,000 beneficiaries each month on a net average basis. Thus far, in 1999, the corresponding increase has slowed to 28,000 beneficiaries each month. [2]

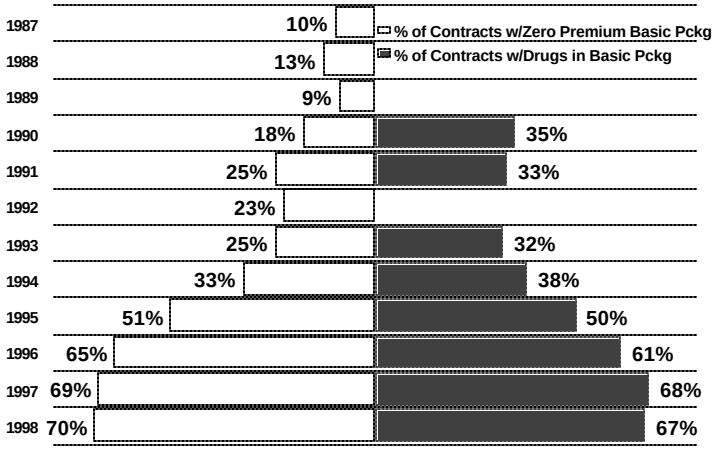
[2] In 1999, the net average monthly enrollment increase has been about 28,000 beneficiaries. This includes the large drop in enrollment due to the decisions made by M+C organizations in 1998 to withdrawal for the 1999 contract year. Subsequent to that drop, M+C enrollment has increased on a net average basis by over 40,000 beneficiaries per month during 1999.

Furthermore, the *rate of increase* in enrollment has declined recently. After 1986, the highest rate of increase in enrollment from one year to the next (36 percent) occurred between 1994 and 1995. Both prior to and after this period, enrollment growth has been more modest. However, the rate of enrollment growth for M+C in the late 1990s still exceeds the rate of growth in the number of beneficiaries entering the Medicare program overall.

The Medicare+Choice Program in the Year 2000

Although the majority of M+C organizations will remain in the program in the year 2000, many of these organizations will increase premiums, as well as reduce and restructure benefits. As a result, enrollee out-of-pocket costs will likely increase. A major factor behind this increase is the rising cost of offering prescription drug coverage—one of most attractive features of M+C for Medicare beneficiaries.

Historical Prevalence of Zero Premiums and Drug Coverage ir Medicare Risk/M+C Contracts, 1987-1998



For missing years, data unavailable. Source: HCFA monthly managed care reports for 1990-1998; adjusted community rate proposals for 1987-1989 data.

Changes in Premiums and Benefits. Since the beginning of the Medicare risk/M+C program, the general trend has been towards an increase in zero premium [3] plans and the inclusion of drug coverage in the basic plan option regardless of any extra benefits (the basic option is generally the lowest-cost option available from an organization.)[4] In fact, since 1994, most plans have offered zero premium plans that

[3] Please see the methodological note for a definition of zero premium.

[4] The paper later explains the difference in basic and optional supplemental benefits coverage.

include drug coverage.[5] While access to a drug benefit has been relatively steady, there has been a decrease in the value of that extra benefit.

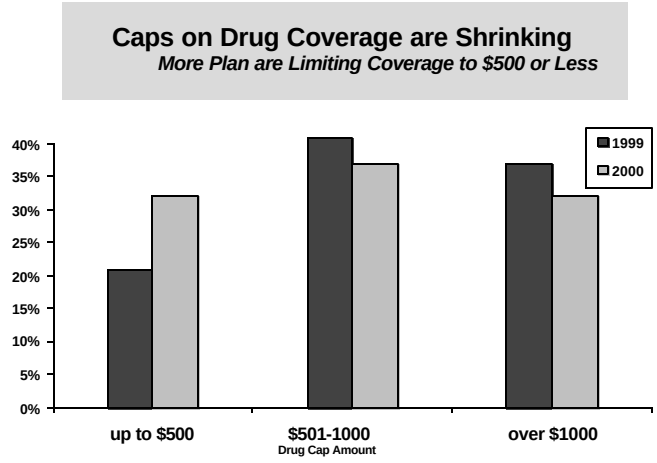
Prescription Drug Coverage. Nationally, the number of beneficiaries with access to an M+C plan offering some prescription drug coverage will remain virtually unchanged next year -- dropping only from 25.4 million beneficiaries (65 percent of the total) in 1999 to 25.2 million (63 percent of the total) in 2000. However, there is significant state-by-state variation. For example, the percent of beneficiaries who will have access to an M+C plan that offers any prescription drug coverage in 2000 will decrease significantly in a number of states, including Louisiana, North Carolina, and Delaware. Also, all available M+C plans will drop drug coverage *entirely* in four states (Arkansa, Iowa, Nebraska, and West Virginia.) At the same time, in a few states (such as Hawaii, Michigan, New Hampshire, and Washington) beneficiaries with access to M+C will have increased availability of drugs. (Please see Attachment A for a full state-by-state analysis.)

Access to Prescription Drug Coverage in Rural Areas is Stable. As mentioned above, there will only be a slight decrease in access to prescription drug coverage nationally. This is also true of rural areas. Among beneficiaries residing in rural counties, the number of beneficiaries whose M+C options do not include *any* level of drug coverage is roughly the same—433,000 in 1999 and 438,000 in 2000. This is an indication that the organizations withdrawing from rural areas generally did not offer drug coverage. While there is no change, the large disparity in access to prescription drug coverage in M+C in rural areas will continue. Only 4 percent of beneficiaries in rural areas will have access to prescription drug coverage through an M+C plan in 2000.

Decreasing Value of Drug Coverage. The *value* of the prescription drug benefit offered by plans will generally decline in 2000. This decline will be due to a number of factors, including decreases in the

[5] With regard to the above chart, "Historical Prevalence of Zero Premiums and Drug Coverage," data for 1999 and 2000 are not available due to changes in the definition of M+C plans and organizations under the BBA.

amount of drug spending covered (particularly for brand-name drugs) and increases in out-of-pocket costs for beneficiaries.



More Restrictive Drug Caps Overall. Although a few additional plans will offer unlimited prescription drug benefits for both generic and brand-name drugs in 2000 relative to 1999, the vast majority of plans (86 percent) will continue limiting drug benefits next year. For organizations that do impose limits, the annual limits are more restrictive for 2000. For example, the percentage of plans with annual benefit limits of $500 or less will increase from 21 percent in 1999 to 32 percent in 2000. Furthermore, 82 percent of plans in 2000 will cap drug coverage below the $2000 level. On an enrollee level, there will be greater availability of unlimited generic drug coverage. At the same time, the caps on brand-name drugs will become more restrictive.

Basic Versus Optional Supplemental Drug Coverage. Although most Medicare beneficiaries will have drug coverage as a feature of their basic M+C plan, more beneficiaries in 2000 will have drug coverage available *only* as optional supplemental. If a covered item is in the basic package, only the plan's standard monthly premium (if any) applies. However, items that are covered as optional supplements require an additional monthly premium to be paid in addition to any premium already being charged for the basic plan. Benefits that are only available from a plan as optional supplemental are, by definition, are more expensive to obtain than benefits offered as basic coverage from that plan.

As a result of program changes, there is a greater likelihood that more generous drug coverage is only available with the payment of the additional premium needed to purchase the optional supplemental benefit. More beneficiaries will have to pay an additional premium for their drug coverage.

Copays for the Drug Benefit -- Plans Are Increasing Levels. Organizations are increasing copays for both brand name and generic drugs.

For the first time, all organizations will require copays for drugs. In 1999, over one million beneficiaries live in areas with an M+C option that allows zero copayments for generic and brand name drugs. In 2000, all beneficiaries in such areas will be subject to copays on both types of drugs.

In 1999, 20 percent of beneficiaries are offered plans with copayments averaging $5 or less for generic drugs. The comparable percentage in 2000 will be three percent. Furthermore, the percentage of all beneficiaries faced with average copayments for generic drugs in the $10 to $15 range will triple. Finally, in 1999, only 274,000 of all beneficiaries live in an area with copayments on brand-name drugs averaging $25 or more. In 2000, there will be one million beneficiaries facing that level of copayment.

Copays and the Drug Benefit -- Beneficiary Charges are Increasing on Average. Overall, M+C enrollees would, on average, be subject to higher copay levels. Assuming M+C enrollment levels remain constant from 1999 to 2000 and that different M+C organizations maintain their same proportion of enrollees, the average copayment for brand name drugs would increase by 21 percent between 1999 and 2000 on an enrollment-weighted basis. Using the same type of analysis, the data show that copays on generic drugs would increase by an average of 8 percent between 1999 and 2000.[6]

[6] As with all the enrollment-weighted analyses, this assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. Due to this assumption, HCFA refers to changes shown by this analysis as those that "would" (as opposed to will) occur. Please see the methodological note for further detail.

Copayment Levels in M+C Plans and Averages Weighted by Enrollment 1999 and 2000[7]		
	Brand-Name Copay: Enrollment Wtd. Avg.	**Generic Copay: Enrollment Wtd. Avg.**
1999	$14.34	$6.88
2000	$17.30	$7.42
Percent Increase 1999 to 2000	21%	8%

Other Benefits. The coverage for other, extra benefits not covered by Medicare fee-for-service (such as dental, vision, and hearing aid benefits) will remain substantially unchanged from 1999 to 2000 in M+C plans. For example, the percentage of the total Medicare beneficiary population living in an area with M+C plans that offer dental benefits will only drop from 83 percent in 1999 to 80 percent in 2000. Similarly, access to vision coverage remains unchanged at 99 percent in both 1999 and 2000.

Changes in Premiums. For 2000, despite some state by state variation, there is a clear trend toward increasing premiums for M+C plans—especially in rural areas. There has been a corresponding decline in the number of zero premium plans. Furthermore, though relatively small numbers of beneficiaries are involved, there will be a significant increase in the number of beneficiaries who will have to pay relatively high premiums to enroll in an M+C plan.

Decline in Zero Premium Plans. In 2000, there will be a decline of more than 3 million in the *number* of Medicare beneficiaries with access to at least one zero premium plan. This represents a decrease in the *percentage* of beneficiaries with access to any plan who will have a zero premium plan, from 85 percent in 1999 to 77 percent in 2000.

[7] This chart includes data from plans with any level of drug coverage in the basic plan.

The corresponding drop in rural areas is greater. One-half million fewer rural beneficiaries will have access to a zero premium plan. In 1999, 1.3 million rural beneficiaries (63 percent of those with any plan available) live in an area with at least one zero premium plan; in 2000, only 784,000 rural beneficiaries (40 percent of those with any plan available) will have such an option.

Some states will see significant changes (positive and negative) in the number of zero premium plans that are available. In the table below, a negative change is an indication that access to zero premium plans is being reduced.

Zero Premium Plan Availability, Changes Over 5% 1999-2000[8]

State	Beneficiaries with Access to Plans	Beneficiaries with Access to a Zero Premium Plan		
		1999	2000	Change
NEW HAMPSHIRE	170,050	100%	0%	-100%
KANSAS	398,171	92%	45%	-47%
ARKANSAS	447,359	72%	35%	-37%
MISSOURI	876,461	88%	56%	-32%
CONNECTICUT	522,372	90%	63%	-27%
PENNSYLVANIA	2,133,804	78%	57%	-21%
WASHINGTON	742,235	82%	61%	-21%
WISCONSIN	797,476	87%	66%	-21%
LOUISIANA	618,618	100%	84%	-16%
NEW JERSEY	1,220,622	100%	86%	-14%
FLORIDA	2,835,297	92%	80%	-12%
MASSACHUSETTS	979,167	100%	94%	-6%
CALIFORNIA	3,937,181	97%	91%	-5%
OHIO	1,735,412	79%	84%	5%
TEXAS	2,273,849	92%	98%	6%
VIRGINIA	885,285	32%	44%	12%
MARYLAND	647,249	83%	96%	13%
WEST VIRGINIA	344,377	0%	32%	32%
TENNESSEE	838,289	50%	83%	33%
OKLAHOMA	516,047	3%	96%	94%

[8] The percentage of beneficiaries with access to a zero premium plan may increase or decrease solely because the number of beneficiaries with access to any M+C plan has increased or decreased.

Increases in Premiums. Data show that there will be an increase in the level of those premiums in M+C. For example, in 1999, the enrollment-weighted average premium for a basic plan was $5.35. For 2000, this amount would almost triple to $15.84.[9] Measured in terms of access to plans across the entire Medicare population, the number of beneficiaries living in areas where M+C premiums are in the $20 to $60 range will increase by approximately 50 percent in 2000 over 1999 representing a shift from lower groups. Finally, for 1999, only 50,000 Medicare beneficiaries live in an area where the minimum premium is in the $80 to $100 range; however, in 2000, the number will rise to 207,000. The majority of such individuals (60 percent) are residents of rural counties.

Premiums in Areas with Only One Plan. Medicare beneficiaries who live in areas with a choice of only one plan will be particularly affected by premium increases. Approximately 8 percent of M+C beneficiaries (just over three million) live in areas with a choice of only one plan. However, of the 207,000 beneficiaries who live in areas where the minimum monthly premium available is over $80, 94 percent (over 195,000) live in areas with only one plan available. There will be a nearly six-fold increase—from 1.6 percent to 9.3 percent—in the percentage of beneficiaries who live in an area where the sole M+C plan available has a monthly premium in the $80 to $100 range for 2000.

Minimum Premium	Medicare Beneficiary Population (Total), Access to Only One Plan			
	Year 1999		Year 2000	
	Beneficiaries	%	Beneficiaries	%
Zero	803,162	31.6%	599,553	28.4%
$0.01 - $19.99	17,614	0.7%	-	0.0%
$20.00 - $39.99	467,284	18.4%	410,662	19.5%
$40.00 - $59.99	716,662	28.2%	683,029	32.4%
$60.00 - $79.99	499,095	19.6%	220,237	10.4%
$80.00 - $99.99	39,742	1.6%	195,432	9.3%

[9] Again, please see the methodological note to learn that the enrollment-weighted analysis assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. This average does not include premiums that beneficiaries pay for supplemental plans.

Totals	2,543,559	100%	2,108,913	100%

Premium increases in areas with only one plan will have the most pronounced impact in rural areas. From 1999 to 2000, roughly the same percentage of beneficiaries who live in rural areas will have only one plan available – 28.4 percent and 29.6 percent in each year respectively. However, the table below shows that zero premium plans are becoming less widely available in rural areas. It also shows that there will be a significant increase in the number of rural Medicare beneficiaries whose only M+C option is a relatively high cost plan.

Minimum Premium	Medicare Beneficiary Population (Rural Only) Access to Only One Plan			
	Year 1999		Year 2000	
	Beneficiaries	%	Beneficiaries	%
Zero	271,833	37.7%	174,956	28.1%
$0.01 - $19.99	17,614	2.4%	-	0.0%
$20.00 - $39.99	96,131	13.3%	104,796	16.8%
$40.00 - $59.99	135,440	18.8%	146,425	23.5%
$60.00 - $79.99	160,647	22.3%	81,774	13.1%
$80.00 - $99.99	39,742	5.5%	115,669	18.5%
Totals	721,407	100%	623,620	100%

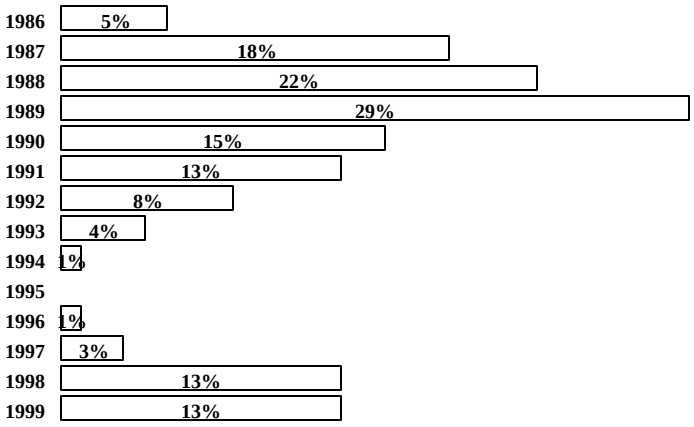
Other Cost Sharing. As with drug coverage, copayments and coinsurance for office visits are increasing. The enrollment-weighted average copayment across all plans for a primary care office visit would increase by 20 percent, from $6.90 in 1999 to $8.33 in 2000. The enrollment-weighted average copayment across all plans for a specialty visit would increase by 37 percent, from $7.67 in 1999 to $10.52 in 2000.[10]

[10] Please see methodological note for information on enrollment-weighted averages.

Access to Medicare+Choice Plans at the End of 1999

This year and last, a number of organizations decided to end or reduce their participation in the M+C program. For 2000, 99 M+C organizations will reduce or drop participation in the program. This includes 41 contractors that completely terminated their M+C contract and another 58 contractors that reduced the size of the service area. These changes will affect 327,000 M+C enrollees (5 percent of enrollees) across 329 counties within 33 states. Of the 327,000 affected, 79,000 M+C enrollees (1.3 percent of enrollees) will have to return to traditional Medicare because they will not have an M+C plan available in their county. This is in contrast to the 407,000 M+C enrollees (6.5 percent of enrollees) affected by contract nonrenewals and service area reductions in 1999. Of the 407,000, 51,000 M+C enrollees (less than one percent of enrollees) were left without access to another M+C plan.

Risk Contract Non-Renewals by Percent of Plans, 1986-1999
(Excludes Service Area Reductions)



Refers only to risk non-renewals (including conversion to cost plans), not service area reductions. The 1989 figure includes 29 plans that had no enrollees. The percent for 1995 was less than one. 1999 data are based on the number of plans as of August 1999.

Terminations of contracts by managed care organizations still remain well below the rates experienced a decade ago. In 1988, 22 percent of Medicare managed care organizations withdrew from the program entirely. This affected 8.2 percent of enrollees.[11] Similarly, in 1989, 29 percent of organizations terminated their contracts, affecting 6.6 percent of enrollees. The high percentage of withdrawals in the late 1980s and then the withdrawals in the late 1990s (13 percent in 1998 and again in 1999) are a stark contrast to the stability experienced from 1993 to 1997.[12]

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[11] The data in this paragraph pertain only to contract terminations, not to service area reductions because HCFA does not have complete historical data on the number of beneficiaries affected by service area reductions.

[12] The term withdrawal is generally used to include both organizations that reduced their service areas or completely terminated their contracts for 2000. In 1998 and 1999, 13 percent of organizations terminated their contracts, with 3.7 percent and 2.7 percent of beneficiaries affected each year (exclusive of service area reductions).

New Plan Approvals Will Increase Availability. Despite volatility in the overall marketplace, new organizations continue to enter the program. Since July 1998, 42 organizations have been approved for participation or expansion in the program. As of August 1999, there were 13 pending applications from organizations seeking new M+C contracts, and nine pending requests for service area expansions.[13] Over 50 percent of the counties included in these pending applications currently have no M+C plans. If approved, these applications would bring M+C access to an additional 1.5 percent of total Medicare beneficiaries.

For 2000, 262 organizations will continue their M+C contracts with Medicare. With the additional 13 new applications, the number of contractors operating in 2000 would be at least 275. As a result, the net percentage decrease in contracting organizations from 1999 to 2000 would be 10 percent --a slightly lower percentage decrease than was experienced in 1998 and 1999 (13 percent in each individual year as shown on the previous page).

New Plan Approvals Will Especially Help Rural Areas. For counties where there were no M+C plans in March of 1999, applications have already been approved that will result in 400,000 additional beneficiaries (living in 87 counties) gaining access to M+C plans for 2000. Of the 400,000 beneficiaries, 47 percent (approximately 200,000 beneficiaries) are residents of rural areas; of the 87 counties, 84 percent are rural. It is also interesting to note that the 400,000 beneficiaries gaining new M+C plans represent only one percent of the total number of beneficiaries; but, the 200,000 rural beneficiaries who will have an M+C plan represent 2.2 percent of rural beneficiaries. For all pending applications from organizations to begin or to expand participation in M+C, 51 percent of the applications are for rural counties. Plans are not simply expanding into high payment areas; only three of the 87 counties being

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With reference to the chart "Risk Contract Non-Renewals," the number of plans in 1999 are for the 2000 contract year.

[13] This does not include the pending application for the private fee-for-service plan.

added will have an M+C payment over $450 in the year 2000 (with 2,200 enrollees in the three counties).[14]

Access to M+C Organizations. As a result of terminations and service area reductions, overall access to M+C options will decline slightly in the year 2000, just as it did in 1999. The percentage of all beneficiaries with access to one or more M+C organizations has declined steadily in recent years --from 72 percent in 1998, to 71 percent in 1999, and to 69 percent for 2000.[15] (Please see Attachment B for a state-by-state analysis of beneficiary access to M+C organizations.)

Access Differences in Rural Areas. Beneficiaries in rural areas will be disproportionately affected by the withdrawal decisions made by M+C organizations for 2000. While access to an M+C plan in urban areas will decline by about 4 percent, access to M+C plans will decline in rural areas by about 10 percent.[16]

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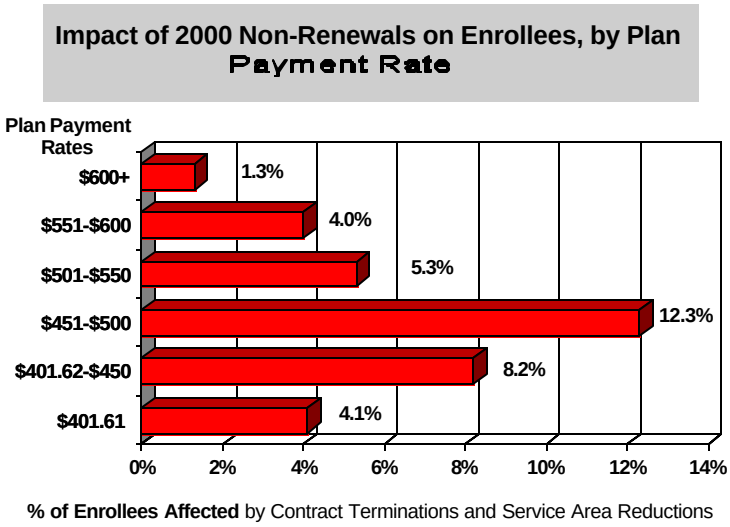
[14] The average M+C base county payment for 2000 for aged beneficiaries, weighted by county beneficiary populations in all US counties, exclusive of US territories, is $513 ($491 in 1999). The simple average of county payment rates for 2000 is $452 ($427 in 1999), with the minimum in the US counties (exclusive of territories) set at $401.61 ($379.84 in 1999), the maximum $814 ($798 in 1999), and the median $435 ($401 in 1999).

[15] The year 2000 figure is based on currently approved organizations. The percentage will increase as new applicants enter the program.

[16] Although 83 percent of urban beneficiaries will have access to M+C plans in 2000 (down slightly from 86 percent of urban beneficiaries in 1999), only 21 percent of rural beneficiaries will have access to an M+C plan in 2000 (down from 23 percent in 1999.) The drop from 21 percent to 23 percent represents a 10 percent shift.

Medicare Revenue and Its Relation to Non-Renewal Decisions. Contrary to assertions by some industry sources, the level of payments to organizations does not appear to explain the decisions by M+C organizations to withdrawal from -- reduce or discontinue participation-- the program. Organizations are primarily withdrawing from counties where payment rates are in a payment mid-range of $451 and $500 for the year 2000. If payment were the primary factor, one might expect withdrawals to be focused in counties with the lowest payments. Only 4 percent of enrollees in counties with the minimum payment level ($401) were affected. Yet, 12 percent of enrollees in counties with payments in the mid-payment rate range of $451 to $500 were affected. Fully, 96 percent of M+C enrollees who are currently in M+C organizations operating in "floor" counties can retain their current M+C plan in the year 2000. Enrollees in counties with the highest payment rates were less likely to be affected by non-renewals. In fact, only 1.3 percent of affected beneficiaries are enrollees in counties where payments are $600 or higher.



Payment will increase in all counties this coming year by an average of 5 percent.[17] The range of payment increases vary from 2 percent to 18 percent.[18] These increases are the result of the Balanced Budget Act (BBA) reforms designed to bring more plan choices to beneficiaries and level the playing field across geographic areas by increasing payment in counties that had the lowest rates. Yet, counties receiving some of the largest increases under the BBA payment system will experience the most disruption. Organization

[17] Calculation based on the average weighted by county Medicare beneficiary populations.

[18] Please note that the 18 percent increase was in an Alaskan county that does not have an M+C option available. The highest percentage payment level increase for a county with an M+C option is 12 percent.

withdrawals will affect 7.2 percent of enrollees in counties where rates will rise by 10 percent or more, but will affect only 2.4 percent of enrollees in counties where rates will rise by the minimum increase of 2 percent.

In addition to M+C payments from HCFA, another source of revenue for M+C organizations is the collection of premiums and other cost sharing from Medicare enrollees. The relation between the availability of a zero premium plan and the level of payment in a given county remains virtually unchanged between 1999 and 2000. If Medicare payments were insufficient for the revenue needs of organizations, one would expect to find zero premium options being limited to the highest payment areas. The data do not show that to be the case.

Average HCFA M+C Payment for Counties with at Least One $0 Premium Plan

	1999			2000		
	Urban	Rural	Total	Urban	Rural	Total
Simple Average	$500.36	$450.49	$483.88	$499.08	$445.02	$483.39
Weighted Average	$539.47	$455.72	$534.41	$535.05	$449.86	$531.57

Comparison of Benefits of Dropped Contracts and Counties to the Overall M+C Program. Organizations withdrawing from M+C are not significantly different than organizations remaining in M+C for the 2000 contract year in terms of benefits. Among all M+C enrollees, 84 percent are enrolled in an organization where the basic plan offers some level of drug coverage. The percentage is similar for enrollees affected by withdrawals; 79 percent are enrolled in an organization where the basic plan offers some level of drug coverage.

Other Factors Affecting Non-Renewal Decisions. In its analysis of the M+C terminations and service area reductions occurring for the 1999 contract year, the General Accounting Office concluded that a variety of factors other than payment rates played a role in organizations' decisions regarding participation

in the M+C program. Given that payment cannot be directly correlated with such decisions regarding M+C contracts for the year 2000, it appears that other factors continue to play a large role in determining the level of organizations' participation in M+C. Among the factors that appear to be relevant in both 1999 and 2000 are M+C enrollment levels in each contract, share of the local M+C market, the ability to maintain adequate provider networks, as well as strategic business decisions specific to a given organization.

Different organizations have made different business decisions regarding their participation in the M+C program. Cigna Corporation has substantially reduced its participation through withdrawals and service area reductions affecting at least a quarter of all the corporations M+C enrollment. Cigna will have about 125,000 remaining M+C enrollees as a result of these changes. By contrast, there will be a minimal effect among enrollees of the largest M+C contractor, PacifiCare, which has over one million M+C enrollees. Fewer than one percent of PacifiCare's M+C enrollees were affected by terminations or service area reductions. The PacifiCare termination involved a contract that included only one county in Oregon, where PacifiCare had a 24 percent M+C market share, but the county is a floor payment county ($401.61 payment in 2000). PacifiCare's service area reductions involved counties where the organization had an average market share of 23 percent, including Eastern Washington, where PacifiCare is leaving both Medicare and commercial markets. However, small numbers were involved. The average number of enrollees in the affected counties is under 1,500 (and the average payment level is $494).

As another illustration, Kaiser is withdrawing from markets in eastern and southern states for both M+C and other lines of business. The organization is terminating the M+C contract of its Capital Area Community Health Plan in upstate New York. A comparison between that contract and Kaiser's M+C contract in Oregon, where the M+C contract will remain in place in 2000, shows that the M+C characteristics are very similar: each has small enrollment, relatively low payment rates, modest benefit packages, and substantial market share (particularly Capital Area), yet Kaiser has chosen to terminate only

one of the contracts. Therefore, it seems that other factors have led to a decision not to renew one of the contracts even though the HMOs' revenues and benefit structure are similar in each location.

	Enrollment (mid-1999)	M+C Market Share	1999 Weighted Monthly Average M+C Payment	Weighted Monthly Plan Premium in Service Area	Nature of Drug Benefit Limit
Kaiser of the Northwest	35,000	26%	$394	$75	Unlimited, but 70% coinsurance
Capital Area	17,000	73%	$419	$25	Annual limit of $500, $1000 varying by county

A number of organizations have made reference to their inability to maintain viable networks in their public statements regarding termination decisions. For example, the Group Health Cooperative in Washington State announced that it was discontinuing operations (for all lines of business, Medicare and others) in eleven rural counties in the State—the first time in the 52-year history of the organization that it has taken such an action. The organization's press release cited its inability to maintain a viable provider network as a contributing factor.

In another example, despite a generous payment rate of $592, Oxford left 9,100 enrollees in Suffolk County, New York because of provider network difficulties.

Parallels of the Medicare+Choice Experience to the Private Sector

Volatility in the marketplace is not confined to Medicare. Program withdrawals, reduced benefits and premium increases are not unique to Medicare. They reflect the industry-wide difficulty organizations have faced in the last few years in controlling costs while attempting to maintain quality and profit levels. These challenges facing managed care organizations have been widely reported in the financial and trade press and are related to the business decisions that organizations are making.

There are many examples of health plans withdrawing from markets other than Medicare. As discussed in the earlier section, PacifiCare is withdrawing from both Medicare and commercial markets in several Washington State counties. Also, Group Health Cooperative is pulling out of both Medicare and non-Medicare markets in 14 counties in eastern Washington and northern Idaho, citing a variety of reasons for its decision. And in several north-eastern markets, Kaiser Permanente is withdrawing from Medicare, Medicaid, and its commercial business, affecting about 500,000 enrollees. Kaiser has specifically said that its withdrawal from these markets cannot be attributed to changes in Medicare payments.

Over the last two years, the Federal Employees Health Benefits Program (FEHBP, with 9 million enrollees) has seen the same kinds of changes that the M+C program has experienced. At the end of 1998, about 20 percent of participating HMOs withdrew from the FEHBP program. At the end of 1999, it is expected that about 13 percent of plans will withdraw from FEHBP. Premiums in FEHBP increased by 7.2 percent for 1998 and slightly over 9.5 percent for 1999. Increases for 2000 will average 9.3 percent.

There also are many examples of health plans raising premiums and reducing benefits in other markets. The California Public Employees Retirement System (CalPERS), which covers over 1 million people, agreed to an average premium increases of 7.3 percent for 1999 and more than 9.7 percent for 2000— the largest premium increase in CalPERS since 1991.

HCFA actuaries are predicting increases of nine percent in private health plan premiums for the year 2000 on average. According to Towers-Perrin, large employers experienced a 7 percent increase in average health insurance premiums for active workers in 1999. One finding in the survey was that rate increases for HMO products in 1999 equaled or exceeded the increases for traditional indemnity plans.

It is essential to note that the large increases now common in the private sector follow several years when private sector increases were quite small--the so-called "underwriting" cycle. In those same years, Medicare increases were two to three times higher than private sector increases, and in fact some financial

analysts have pointed out that Medicare revenues subsidized premiums of other payers. Those years of excessive Medicare payment increases greatly contributed to the ability of organizations to provide generous benefit packages. As the cycle continues, plans are finding that they cannot use Medicare revenues to subsidize other lines of business despite statements made by the General Accounting Office and others that M+C pays plans more than adequately for the provision of the Medicare benefits package.

Conclusions

Managed care organizations are now experiencing programmatic and financial challenges. Although public and private markets are structured somewhat differently, managed care's difficulties are producing important changes that affect all their products, including their participation in M+C.

Organizations are increasing premiums for private and public sector purchasers alike. Enrollees (in both private and public products) are finding that many plans are restructuring benefits to increase cost sharing or reduce the level of coverage available (particularly for drug coverage). In M+C, there has been clear movement towards rethinking market strategies--including corporate decisions to exit particular markets. Moreover, there is a movement towards increasing out-of-pocket costs for enrollees and reducing the level of benefits provided. At the same time, the M+C program continues to receive new applications that will increase access to managed care for beneficiaries, especially in lower paid areas.

METHODOLOGICAL NOTE

Definitions

- **Plans and Organizations** -- In a context other than Medicare+Choice (M+C), the term *plan* (or *health plan*) is generally understood to mean a health benefit offering of a particular insurance company or health maintenance organization (HMO.) In Medicare, the term has a special meaning as a result of provisions of the Balanced Budget Act of 1997 (BBA). Prior to the BBA changes, a Medicare-contracting HMO was commonly referred to as a "plan," and the plan could offer a variety of benefit packages—for example, one plan could offer several optional supplemental benefit packages available to Medicare enrollees for an additional premium; or a plan could vary its Medicare benefit offerings in different counties, under certain circumstances. The BBA changes give a specific meaning to the term *plan* that is different from prior usage of the term. Under the BBA, the various offerings of a contracting HMO or other organization are referred to as "plans." The "plans" may vary by the level of benefits provided ("plans" that offer extra benefits for enrollees choosing to pay an additional premium); or they may vary by the structure of the "plan" (one organization may offer a "plan" structured as a PPO under its M+C contract while, at the same time, offering, in the same service area, a "plan" structured as a closed-panel HMO). The term *plan*, under the BBA, continues to include what were referred to in pre-BBA terminology as "high option" plans or supplemental offerings available for an additional premium (please see below for a definition of optional supplemental coverage.)

  Under the BBA provisions, "plans" offered by an *organization* may have different service areas under a single contract. However, each "plan" offered by a contracting organization must have a uniform benefit and premium structure throughout the approved service area of the "plan"; that is, once a "plan" is offered in multiple counties under one contract, all residents of all the counties where the "plan" is offered must receive the same level of benefits if they choose that plan. Another way in which an M+C organization may offer more than one plan under one contract is through "segmented service areas." The segmented service area provision is the successor to the pre-BBA

"flexible benefits" policy under which an organization could vary premiums and benefits under one contract on a county-by-county basis. The segmented service area policy allows organizations to essentially set up multiple service areas under a single contract in such a way that each sub-service area has a different "plan" (enabling the organization to comply with the BBA requirement of uniform premiums and benefits within a service area—a requirement that applies at the plan level, not at the organization level).

- **Zero Premium** -- If there is not a monthly charge beyond the regular Part B Medicare premium to enroll in a risk/M+C organization, then the organization is said to have a "zero premium." All M+C enrollees must continue to pay their Part B premium (or have it paid on their behalf). Organizations that charge the beneficiary a monthly amount in addition to the Part B premium to enroll are not considered zero premium organizations.

- **Beneficiaries and Enrollees** -- For reasons described in the Methodology Section of this Note, beneficiary and enrollee are used in specific ways for purposes of this paper. "Beneficiary" is used to refer to all Medicare beneficiaries—those both enrolled in original fee-for-service Medicare and those enrolled in M+C. "Enrollee" is used to refer to those persons actually participating in a managed care plan --whether that plan is part of M+C or a private program.

Methodology

The analyses in this paper present data from a variety of sources. However, the analysis is primarily based on data submitted by M+C organizations to HCFA. Data are arrayed and presented along different dimensions, but generally fall into one of three categories:

- Plan-level data,
- Population-level data, based on the level of the total Medicare beneficiary population in a county, a state, a sub-area (e.g., rural areas), or in the nation as a whole, and

C Enrollment-level data, based on enrollment in M+C organizations in 1999.

Plan-Level Data. BBA policy changes related to the designation of "plans" applied to M+C contracts for 1999. In 1999, although there are about 300 contracting organizations, 622 "plans" are offered to beneficiaries by M+C contractors. In the year 2000, although there will be about 260 contractors, they will offer 793 different plans to beneficiaries. These 793 plans include both the "high option" supplements available for an additional premium, as well as "plans" that represent inter-county variation in premiums and benefits. The growth in segmented service areas has contributes to the growth in the number of plans.

The plan-level analyses in the paper are analyses across all "plans" under the BBA definition of the term. For example, in the data, an average premium among all plans would be computed across all 793 plans in 2000, or across all 622 plans in 1999. Because the set of "plans" includes optional supplemental packages, and HCFA does not collect data on the number of M+C enrollees who elect optional supplements offered by their M+C organization, the plan-level analysis only provides a rough indicator of what is happening at the beneficiary level. However, the plan-level analysis can provide an indication of the general trends and changes from year to year in plan offerings that beneficiaries will see. In addition, the plan level analysis does not account for the fact that each plan contains a different number of enrollees. By failing to appropriately weight the policies of a given plan by the number of enrollees in that plan, this type of analysis may not provide an accurate picture of how the enrollee population is affected by a given policy.

Population-Level Data. Another way in which data are presented in this paper is at the level of the overall Medicare beneficiary population. Plan benefits and premiums are analyzed in terms of the number of Medicare beneficiaries residing in the counties in which the M+C organizations are offering their plans. That is, the data provide a means of showing what beneficiaries across the Nation—including beneficiaries enrolled currently in an M+C plan, as well as those not enrolled currently—can expect in the way of benefit offerings from M+C organizations operating in the counties where they live. Overall access figures (e.g.,

data on whether or not any M+C plan is available to beneficiaries) are also presented using beneficiary population numbers that include both beneficiaries enrolled in M+C plans and non-enrollees. The population-level data in almost cases are combined with plan-level data. For example, a statement to the effect that a certain number of beneficiaries will have access to plans in which the average premium level is a certain dollar figure includes an averaging across all "plans." For 2000, the analysis assumes the beneficiary population by county as February 1, 1999.

Enrollment-Level Data. Until beneficiaries decide, for the year 2000, whether to continue their M+C enrollment, change to another M+C organization, or newly enroll into or disenroll from an M+C organization, enrollment levels for 2000 will not be known. However, in order to provide more information about what kinds of changes in their premiums and benefit packages beneficiaries may see in the year 2000, this paper provides an analysis of the differences between 1999 and the year 2000 in *basic benefit packages* offered by M+C organizations that were operating in February of 1999 and will continue to operate in the year 2000. To offer an indication of the possible impact of benefit changes on the current M+C enrolled population, the analysis uses the actual distribution of enrollment in 1999 to assign enrollment numbers to organizations for the year 2000 for purposes of analyzing the data on benefits and premiums and to examine how beneficiaries may be affected by changes made by the organizations in which they are currently enrolled. That is, the analysis presents the changes in the M+C program using the assumption that (a) enrollment levels will remain the same, and (b) different organizations will have the same proportion of M+C enrollment, as a share of overall M+C enrollment, that they had in 1999.

An element of the enrollment-level analysis is the identification of a basic benefit package (or basic "plan") in 1999 and 2000 to establish the minimum level of benefits available to an M+C enrollee in a particular organization. The basic package is also used as the unit of analysis because, as noted above, HCFA does not have enrollment information regarding optional supplemental packages.[19] The basic package is

[19] Beneficiaries enrolled in M+C plans as employer-sponsored retirees may have additional benefits beyond those offered to individual Medicare beneficiaries; however, HCFA does not collect data on the nature of such benefits.

identified at the county level to account for segmented service areas (which would have different benefit packages). It is generally assumed that a plan that has a zero premium is the basic package. Where two plans in the same county offered by the same organization have a zero premium, the plan with the more generous benefit package is assumed to be the basic plan (particularly if one plan provides some level of drug coverage and another zero premium plan offered in the same county by the same organization does not). Co-existing zero premium plans may be offered by one organization in the same county for a number of reasons. One of the organization's zero premium plans may have extra benefits covered because the competing zero premium plan is a point-of-service option allowing greater use of non-network providers. In certain states, organizations may also offer zero premium plans that do not include drug coverage (but have, for example, lower copayments for physician visits) along with a zero premium plan that does cover drugs. This is done in order to offer a "plan" that is attractive to Medicare beneficiaries who obtain their drug coverage from sources such as state pharmacy assistance programs. In such a case, the analysis treats the plan with a zero premium *and* drug coverage as the "basic package" offered to any Medicare beneficiary residing in the county where the organization offers various plans. Where multiple options are offered by the same organization and all require the payment of a premium (beyond Medicare's Part B premium), the lowest-cost plan is assumed to be the basic plan.

The enrollment-level data therefore:

- Impute enrollment levels for 2000, based on a methodology that assumes, essentially, that enrollment levels, and the enrollment distribution among plans, remain static between 1999 and 2000;
- Refer only to what the analysis treats as a "basic benefit" in each county for each organization (i.e., one "plan" is chosen to be the basic benefit package for each organization operating in a county); and
- Present data aggregated at the imputed enrollment level. For example, an enrollment-weighted premium for this group would be the actual average premium across all unique basic plans in 1999. The imputed year 2000 average enrollment-weighted premium for the unique basic plan average

across the 1999 enrollees of the organizations in the individual counties that the organization continues to include in its service area.

ATTACHMENT A

Changes in Access to Any Drug Coverage for Beneficiaries with Access to at Least One M+C Plan 1999-2000 *Negative change indicates drop in coverage.*			
State	**1999**	**2000**	**Change**
AK	100%	100%	0%
AL	0%	0%	0%
AR	37%	0%	-37%
AZ	100%	100%	0%
CA	99%	98%	-1%
CO	100%	100%	0%
CT	100%	100%	0%
DC	100%	100%	0%
DE	100%	58%	-42%
FL	97%	98%	0%
GA	100%	100%	0%
HI	0%	100%	100%
IA	100%	0%	-100%
ID	100%	100%	0%
IL	92%	92%	0%
IN	100%	100%	0%
KS	100%	100%	0%
KY	100%	100%	0%
LA	93%	84%	-10%
MA	100%	100%	0%
MD	100%	100%	0%
ME	100%	100%	0%
MI	89%	100%	11%
MN	100%	100%	0%
MO	100%	100%	0%
MS	100%	100%	0%
MT	100%	100%	0%
NC	72%	18%	-55%
ND	0%	0%	0%
NE	100%	0%	-100%
NH	72%	100%	28%

Changes in Access to Any Drug Coverage for Beneficiaries with Access to at Least One M+C Plan 1999-2000 *Negative change indicates drop in coverage.*			
State	**1999**	**2000**	**Change**
NJ	100%	100%	0%
NM	100%	80%	-20%
NV	100%	100%	0%
NY	89%	88%	-1%
OH	98%	96%	-2%
OK	100%	100%	0%
OR	65%	66%	1%
PA	97%	93%	-4%
RI	100%	100%	0%
SC	0%	0%	0%
SD	0%	0%	0%
TN	81%	82%	1%
TX	96%	95%	0%
UT	0%	0%	0%
VA	63%	100%	37%
VT	0%	0%	0%
WA	10%	88%	78%
WI	100%	100%	0%
WV	62%	0%	-62%
WY	0%	0%	0%

ATTACHMENT B

Beneficiaries with Access to an M+C Plan 1999 to 2000 *Negative change indicates drop in coverage.*			
State	**1999**	**2000**	**Change**
AK	0.0%	0.0%	0.0%
AL	28.6%	28.6%	0.0%
AR	31.0%	31.1%	0.1%
AZ	100.0%	94.3%	-5.7%
CA	95.1%	95.0%	-0.1%
CO	81.2%	81.7%	0.4%
CT	100.0%	97.1%	-2.9%
DC	100.0%	100.0%	0.0%
DE	58.0%	100.0%	42.0%
FL	84.1%	82.6%	-1.5%
GA	36.6%	34.8%	-1.8%
HI	95.0%	100%	5.0%
IA	2.9%	2.9%	0.0%
ID	28.4%	28.6%	0.2%
IL	68.5%	68.5%	0.0%
IN	34.6%	34.7%	0.1%
KS	35.2%	35.3%	0.1%
KY	25.8%	25.8%	0.0%
LA	87.1%	59.6%	-27.5%
MA	96.9%	97.1%	0.2%
MD	100.0%	82.0%	-18.0%
ME	62.8%	63.1%	0.3%
MI	62.6%	62.7%	0.1%
MN	48.4%	48.6%	0.2%
MO	58.5%	58.6%	0.2%
MS	0.0%	0.0%	0.0%
MT	0.0%	0.0%	0.0%
NC	46.8%	47.0%	0.2%
ND	0.0%	0.0%	0.0%
NE	26.0%	23.4%	-2.7%
NH	64.5%	46.7%	-17.8%
NJ	100.0%	100.0%	0.0%
NM	65.5%	65.9%	0.4%
NV	88.7%	89.6%	0.9%
NY	91.0%	90.6%	-0.4%

Beneficiaries with Access to an M+C Plan 1999 to 2000 *Negative change indicates drop in coverage.*			
State	**1999**	**2000**	**Change**
OH	84.9%	87.0%	2.1%
OK	80.7%	77.4%	-3.3%
OR	81.6%	81.1%	-0.4%
PA	96.2%	96.3%	0.1%
RI	100.0%	100.0%	0.0%
SC	11.6%	0.0%	-11.6%
SD	0.0%	0.0%	0.0%
TN	73.5%	60.1%	-13.3%
TX	73.3%	71.5%	-1.8%
UT	0.0%	0.0%	0.0%
VA	53.1%	33.5%	-19.6%
VT	0.0%	0.0%	0.0%
WA	84.7%	82.6%	-2.1%
WI	42.8%	50.6%	7.8%
WV	36.2%	20.5%	-15.7%
WY	0.0%	0.0%	0.0%